STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155070	A. BUILDING 00 B. WING	06/10/2011

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: June 6, 7, 8, 9, 10, 2011 Facility number: 000028 Provider number: 155070 Aim number: 100275370 Survey team: Donna Groan, RN, TC Avona Connell, RN Gloria Reisert, MSW June 6, 8, 9, 10, 2011 Dorothy Navetta, RN June 6, 7, 8, 9, 2011 Census bed type: SNF/NF: 116 Total: 116 Census payor type: Medicare: 10 Medicaid: 88 Other: 18 Total: 116 Sample: 24 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.	F0000	This plan of Correction is submitted under Federal and State regulations and status applicable to long-term-care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility and such liability is hereby denied. The submission of this plan does not constitute an agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are cited correctly. Furthermore, we request this Plan of Correction serve as our credible allegation of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F0164 SS=D	Quality review 6/16/11 by Suzanne Williams, RN The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. Based on record review and interview, the facility failed to ensure personal and medical information contained in the dialysis binder was kept safe and confidential for 1 of 2 dialysis residents reviewed in a sample of 24. (Resident #109) Findings include:	F0164	Resident #109's dialysis communication binder was located and returned to facility by the ambulance service on Saturday 6/11/11. Residents who receive dialysis services have the potential to be affected by the alleged deficiency. An audit was completed on 6/28/2011 to ensure that no other residents were affected by the alleged deficient practice, and none were found to be out of	07/10/2011

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	The clinical record for Resident #109 was reviewed on 6/8/11 at 1 p.m. The resident's diagnoses included, but were not limited to, chronic kidney disease with dialysis. At the time of review, the facility could not locate the blue dialysis book containing correspondence with the dialysis center. On 6/9/11 at 2:30 p.m., the Director of Nursing indicated the blue dialysis book was not at the dialysis center and the EMS (Emergency Medical Service) indicated the binder was left in the ambulance on the stretcher. On 6/10/11 at 9 a.m., the Assistant Director of Nursing provided the dialysis information which was faxed on 6/9/11 at 4:22 p.m. from the [named] dialysis center. The information was for treatment received from May 26, 2011 thru June 9, 2011. Signed Physician Orders, dated 6/11, indicated the resident was receiving dialysis three times a week since 1/30/11. In interview with the Director of Nursing on 6/11/11 at 11:35 a.m., he indicated the information from the dialysis center was sent yesterday evening at the facility request. He wanted the last two weeks, as the dialysis center nor the EMS could find the resident's blue binder. He wanted to recreate the binder. Hours have been		compliance. New facility protocol will be for the Dialysis Centers to begin faxing the facility a report after each visit to ensure communication between facility and center occurs. DON spoke with the DON at FMC Dialysis center on 6/28/2011 and to Regional Coordinator with Davita Dialysis on 6/29/2011 to notify them of new facility protocol and they agreed to assist and comply with request. Don or Designee will complete weekly audits X 4 weeks and then monthly to ensure Dialysis Center communication sheets are received and filed appropriately. Results from the audits will be reviewed monthly at the PI Committee Meeting for a minimum of one year to ensure 100% compliance. System will be updated as indicated. After 1 year if 100% compliance has not been achieved, the PI observations will continue to be conducted monthly and reviewed until 100% compliance has been achieved.	

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	spent trying to locate the book. On 6/06/11 at 10 a.m., the Facility Admission Packet was reviewed. The packet contained a copy of the Residents Rights which included, but was not limited to "The resident has the right to personal privacy and confidentiality of his or her personal and clinical records." On 6/10/11 at 12:35 p.m., the Administrator provided the policy and procedure for "Notice of Privacy Practices" dated 12/29/08 which included, but was not limited to "Your Health Information Rights. Our Responsibilities. The Facility is required to: maintain the privacy of your health information." On 6/10/11 at 1:45 p.m., the Administrator indicated neither the dialysis center nor the ambulance service could find the blue binder containing confidential information related to Resident #109 and his treatment at the dialysis center, which was a communications binder between the facility and the center. 3.1-3(o) 3.1-3(p)(3)			

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F0250 SS=D	The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interview, the facility failed to ensure medically related social services were provided for 1 of 1 resident reviewed for dental services in a sample of 24. (Resident #44) Findings include: The clinical record for Resident #44 was reviewed on 6/7/11 at 3:25 p.m. A consult dentist note dated 08/20/10 included, but was not limited to "Nothing hurting or bothering patient at this time. Eating just fine. Patient has several (sic) teeth that are present. Dr. [named] highly recommends a professional cleaning at our office. A letter was sent to patient's resp. (responsible) party to see if this can be arranged." A hand written note on the form indicated "9/27/10 [named daughter] will take her after Oct. 15th. Dtr (Daughter) to make appt. (appointment)." In interview with Social Worker #2 on 6/9/11 at 2:10 p.m., she indicated it was her responsibility to follow-up with the daughter to ensure the dental appointment was made. Documentation was lacking in the Social Service notes of any follow-up since 9/27/10.	F0250	The professional cleaning dental recommendation for Resident #44 has been reviewed. The Resident's responsible party/daughter has provided written documentation that she was and is aware of this recommendation. Resident attended an appointment at Dr. Hartman's Office on 6/30/11 at 11 am. Transportation was provided by Mission Transportation. Residents receiving contracted in-house dental services have the potential to be affected. An audit of residents currently residing in the facility that receive contracted dental services was completed on 6/28/2011. The audit reviewed any recommendations for additional outside dental consultations (i.e. oral surgeon referrals) during the past 90 days. The audit revealed there were no outside dental referrals that had not been followed-up on. Social Services staff and a representative from nursing will be assigned to round with the dental physician(s) during in-house consultations to ensure that new orders or recommendations are received, documented and processed. Social Services staff was in-serviced on 6/24/11 by	07/10/2011

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	On 6/9/11 at 2:12 p.m., the Administrator provided a copy of the Job Description for the Director of Social Services which included, but was not limited to "Essential Functions: Bullet #3 Must be able to design social service program that meets the medically-related social and emotional needs of residents as well as state, federal, corporate, and division guidelines. Bullet #5 Must be able to chart appropriately and timely; Bullet #6 Must be able to assist resident and family through education, financial planning assistance, liaison with community agencies, etc." 3.1-34(a)		Lacy Beyl & Co. on case management to ensure medically related social services are provided. New orders related to dental referrals requiring additional outside referral services will be reviewed in the Monday-Friday department head meeting. The orders will then be taken to the Monday-Friday clinical meeting to ensure that the resident's care plan is updated as indicated. Don, SSD or designee will audit new telephone orders received dental consultations weekly x 4 weeks, and then monthly to ensure orders have been processed additional outside referrals have been obtained or scheduled, and that the care plans have been updated as indicated. Results from the audits will be reviewed monthly at the PI committee meeting for a minimum of 1 year to ensure 100% compliance. Systems will be updated as indicated. After 1 year, if 100% compliance has not been achieved, the PI observations will continue to be conducted and reviewed at the PI Committee meeting until 100% compliance has been achieved.	
F0253 SS=E	The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation, record review and interview, the facility failed to ensure furniture, window sills, over the bed lights were clean and in good repair. The	F0253	Areas identified during the survey were cleaned and or repaired. All Residents have the potential to be affected by the deficient practice. Resident rooms and	07/10/2011

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	deficient practice affected 4 of 21 rooms on the 300 hall; 2 of 18 rooms on 100 hall; and 2 of 4 dining areas and 1 of 1 lobby. These deficient practices had the potential to effect 61 residents who resided on the 100, 200, 300 and 600 halls of 116 residents in the facility. Findings include: On 06/06/11 at 7:53 a.m. the following was observed: 1. The wood frames of 13 of 13 chairs in the main dining room were soiled with heavy black dust that rolled up when swiped with the finger. The wood table with the Prayer box had heavy dust on the bottom wood piece. 2. The wood frames of 24 of 24 chairs in the 600 hall lounge/dining area were covered. soiled with heavy dust that rolled up when swiped with the hand. Between the hours of 12:38 p.m. and 1:15 p.m. the following was observed: 3. In the main lobby the wood frames of 6 chairs, and wood dresser pedestal was soiled with heavy dust. 4. Room 317 --Two over bed lights were soiled with heavy dust and two screws were protruding from the wall approximately 1/4 inch on the wall		common areas were cleaned/dusted with repairs made on or prior to 6/24/2011. The Environmental Services Director inserviced ES staff on 6/24/2011 regarding expected cleaning duties and schedules. New Environmental Services staff will be trained on cleaning schedules duties and schedules during orientation. Re-education will be provided by the Environmental Services Director or designee for any occurrence on non-compliance noted. The Environmental Services Director or designee will audit two Resident Rooms on each unit daily Monday-Friday X 4 weeks then monthly to ensure rooms are clean and in good repair. In addition, the common areas and dining rooms will be audited daily to ensure they are clean and in good repair. Environmental services audits will be reviewed monthly at the PI Committee Meeting for a minimum of 1 year to ensure the facility is clean and in good repair. Systems will be updated as indicated. If after 1 year, 100% Compliance has not been achieved, PI observations will continue to be conducted monthly and reviewed at the monthly PI committee meeting until 100% compliance has been achieved.	

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	by the hand sink. 5. Room 320-- The frames of both beds were soiled with dust and one bed frame was soiled with a slimy substance. The cleaning schedule for "Resident Rooms" and "Floor Tech" was provided by the Housekeeping supervisor on 06/09/11 at 10:15 a.m. for resident rooms and common areas. . In interview at this time he indicated the cleaning was to be done on a daily basis. The "Room Cleaning " schedule indicated the following: Number 2. "High dust, sprinkler heads, vents and all high areas including tops of closets, work your way downward, get beds and all furniture from top to bottom" The "Floor Tech" schedule indicated that daily between 7:45 a.m. and 9:00 a.m. and Clean lobby and offices --vacuum empty trash, dust...." Between 9:00 a.m. and 9:30 a.m." Clean main dining room wipe down chairs, and all horizontal surfaces." 3.1-19(f)			

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F0272 SS=D	The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. Based on record review and interview, the facility failed to ensure a resident who was declining was assessed timely for 1 of 2 residents reviewed with a significant change in a sample of 24. (Resident #121) Findings include:	F0272	Resident # 121 no longer resides in the facility. However, no harm was incurred by the resident related to the alleged deficient practice. A 100% audit of the daily 24 hour report sheets will be completed on 6/29/2011 of the past 30 days to assist in identifying any residents who may have experienced a change of condition. Documentation of the assessment(s) completed will be	07/10/2011

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	The clinical record for Resident #121 was reviewed on 6/8/11 at 9:22 a.m. The resident's diagnoses included, but were not limited to Alzheimer's and stroke. The Nurse's Notes included, but were not limited to "3/4/11 2 00 p.m. Resident right upper arm remains swollen yellow in collor (sic) with some purple discoloration noted Unit manager and MD notified." The next nurse's note was dated "3/6/11 230 p.m. Placed call to Dr. [named] office about the swelling in Residents RUE (Right Upper Extremity). Have been keeping elevated on pillow but still having +2 to +3 edema (swelling)...Arm's red to yellow to purplish green. Will await MD call and will cont (continue to monitor resident...." Documentation was lacking of an assessment from 3/4/11 after 2 p.m. until 3/6/11 at 2:30 p.m.. 48 hours passed without an assessment by staff. In interview with the Director of Nursing on 6/8/11 at 1:12 p.m., he indicated there was no documentation between those hours. 3.1-31(a)		reviewed to ensure adequate documentation has been completed. 24 hour report sheets for each unit will be reviewed daily Mon-Fri during the daily Dept. Head meeting. Any resident(s) identified to have experienced a change in their condition will be further reviewed in the daily Clinical Mtg. to ensure adequate documentation has been completed. Licensed nursing staff were re-educated 6/29/2011on the importance of completing and documenting resident assessments as indicated. Newly hired licensed nursing staff will be trained on importance of completing and documenting resident assessments as indicated. In addition, licensed nursing associates will receive re-education on this policy and procedure when completing annual skill competencies. DON or designee will complete a random audit weekly x 4 weeks then monthly of at least 4 medical records for resident(s) that may have experienced a change in their condition to ensure adequate documentation is being completed.	

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F0323 SS=E	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure hazardous materials and the Hydrocollator (moist heat used in therapy) were secured properly. This deficient practice had the potential to affect 1 of 5 residents who currently resided on the 600 hall and 16 of 25 residents who currently resided on the 100 hall with cognitive impairment, as identified on the current facility resident roster. Findings include: 1. On 06/06/11 at 8:01 a.m., the following chemicals were observed under the sink in the 600 hall/lounge/dining area. A quart of VirexTB (ready to use disinfectant cleaner) and a bottle of Zephair (air freshener). No staff were in attendance. At 8:05 a.m., in interview, the housekeeping supervisor indicated the chemicals were not to be under the sink. 2. On 06/06/11 at 12:25 p.m., the door to the therapy room was standing open. No staff were in attendance. The following items were observed in the room:	F0323	Hazardous materials (i.e Virex TB, Zephair, Super Sani-Cloths, and Paraffin) and the hydrocollator packs have been properly secured on 6/6/2011. The Good Sense Air Freshener was properly secured on 6/7/2011. Residents with cognitive impairment have the potential to be affected. Further observation was conducted on 6/6/2011 and 6/7/2011 throughout facility to ensure that potentially harmful chemicals and equipment were secured appropriately. Therapy staff was inserviced on 6/6/2011 and ES staff was in-serviced on 6/24/2011 regarding the importance of adequately securing chemicals and hazardous equipment. On 6/23/2011 a self-closing device was placed on the door to the therapy room where the hydrocollator and paraffin are kept. The door will automatically lock when and close. Director of Environmental Services, RSM or designee will perform random daily rounds throughout the facility ensuring potentially harmful chemicals and equipment are secured appropriately X 4 weeks then weekly X 4 weeks and monthly X 10 months. Results of the observations will	07/11/2011

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	Two containers of Super Sani Cloths labeled "Keep out of reach of children." A container of Paraffin. The temperature of the Paraffin measured 122 degrees. A container of water that contained three Hydrocollator packs. The temperature measured 166.5 degrees. In interview with the rehab manager at 12:33 p.m., on 06/06/11, she indicated the room was supposed to be locked when staff were not in attendance. 3. On 06/07/11 at 5:43 p.m., a bottle of Good Sense Air Freshener was observed on the floor by the door in the 600 hall lounge/dining area. The Material Safety Data Sheet for the VirexTB was provided by the Director of Nursing on 06/08/11 at 9:25 a.m. and for the Zephair at 10:45 a.m. The sheets were reviewed at 11:00 a.m., on 06/08/11. First Aid Measures for the VirexTB indicated the following: Eye contact: Hold eye open and rinse slowly and gently with water for 15 - 20 minutes. Remove contact lenses, if present, after the first 5 minutes, then continue rinsing eyes. If irritation persists, get medical attention. Ingestion: Immediately drink one cupful of water or milk. Get medical attention.		be reviewed at the monthly PI meeting. Systems will be updated as indicated. If after 1 year, 100% compliance has not been achieved, audits will continue on a monthly basis.	

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First Aid measures for Zephair indicated the following:
Eye contact: In case of contact, immediately flush eyes with plenty of water. Remove contact lenses and flush again. Get medical attention if irritation persists.
Ingestion: Do not induce vomiting. Never give anything by mouth to an unconscious person. If irritation persists, get medical attention.

The Director of Nurses provided the Material Safety Sheet for the Good Sense Liquid Air Freshener on 06/07/11 at 6:06 p.m. The sheet was reviewed at this same time.

First Aid Measures were listed as follows:
Eye contact: Flush immediately with plenty of water. If irritation develops get medical attention.

On 06/10/11 at 12:`10 p.m., the Director of Nursing provided the Material Data Safety Sheet for Sani-Wipes. The information was reviewed at this time.

First Aid Measures:
Eyes: Flush eyes;yes and under eyelids with plenty of water for at least 15 minutes. Obtain medical attention.
Ingestion: Contact physician or poison

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	control center immediately. Rinse mouth with water and give affected person one to two glasses of water. Do not attempt vomiting. Never give anything to an unconscious person. 3.1-45(a)(1)			
F0329 SS=D	Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on record review and interview, the facility failed to ensure the residents' drug regimen was free from unnecessary psychotropic, anti-anxiety and hypnotic usage without adequate monitoring and indications for use for 3 of 3 residents reviewed for unnecessary drug usage in a sample of 24 residents. (Residents #20,	F0329	Upon review of Resident # 20's medical record, documentation is present in Resident # 20's medical record from November 2010 thru April 2011 in the Psychiatrist's Follow-up Evaluation Sheet and the Pharmacists review sheet that validates compliance that the house psychiatrist and the	07/10/2011

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	36, and 104) Findings include: 1. Review of the clinical record for Resident #20 on 6/8/2011 at 9:25 a.m., indicated the resident had diagnoses which included, but were not limited to, senile dementia with behavior disturbance, depressive disorder, and psychosis. The June 2011 monthly physician orders signed by the physician on 6/1/2011 indicated the resident was receiving the following psychotropic and anti-anxiety medications: - Buspar (for anxiety) 10 milligrams [mg] - give 2 tablets orally 3 times a day - ordered on 5/3/2010. - Depakote (for psychosis) 125 mg - give 2 capsules orally 2 times a day - ordered on 5/3/2010 - Depakote (for dementia with behavior disturbance) 125 mg - give 3 caps orally 2 times a day - ordered on 5/3/2010. - Neurontin (for anxiety state) 100 mg - give 1 capsule orally 3 times a day - ordered on 5/3/2010 - Neurontin (for anxiety state) 100 mg - give 2 caps orally at bedtime - ordered on 5/3/2010 - Lexapro (for depressive disorder) 10 mg - give 1 tablet orally once a day - ordered on 5/3/2010 - Lorazepam (for anxiety) 0.5 mg - give 1/2 tablet orally 2 times a day - ordered on 5/9/2011 (was 0.5 mg - 1/2 tablet 3 times a day) - Remeron (for depressive disorder) 15 mg - give 1 tablet orally at bedtime - ordered on 5/3/2010		Pharmacy consultant assessed the resident's need for a GDR monthly. Additionally, there is no documentation found in the notes that the resident was experiencing any of the above noted changes that supports a change in the resident's treatment plan and that the current medication regimen was effective. On 5/9/2011, the resident experienced some increased drowsiness which the Psychiatrist addressed at that time to include changes in the resident's medication regimen.Resident # 104's, P.O.A. is involved in this resident's care on a daily basis for several hours throughout the day and evening. She is aware and participates in the decision process for medication changes. In interview with the P.O.A., she verifies that she requested a GDR not be attempted. For residents # 20, #36, and # 104 documentation has been added to the medical records supporting the changes/GDR's of the medications by nursing and social services. Residents receiving psychotropic medications have the potential to be affected by the alleged deficient practice.An audit of residents receiving a psychotropic medication within the last 90 days was completed on 6/29/2011 to evaluate if the need of a GDR per the facilities policy. The audit revealed that the need of a GDR has been	

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	- Risperadol (for psychosis) 2 mg - give 1 tablet orally every 12 hours - ordered on 5/3/2010 Review of nursing notes, social service notes and the Behavior Monitoring Flow records between 11/2010 and 6/2011 failed to locate documentation of the resident having experienced any behavior/mood issues. During a medication pass observation of Resident #20 on 6/6/2011 at 7:45 a.m. in her room, the nurse was observed having difficulty arousing the resident and was unable to give the resident her medications. Observations of the resident on 6/8/2011 at 10:45 a.m., on 6/9/2011 at 11:03 a.m., and at 12:15 p.m., observed the resident in her room in her wheelchair asleep. The resident did not respond to her name being called. During an interview with LPN #2 on 6/9/2011 at 11:06 a.m., she indicated the resident was wide awake this morning at breakfast and talking. She indicated the resident was sometimes difficult to arouse and that she thought the resident sometimes played "possum" as she chose whether she wanted to talk to you or not. During an interview with LPN #3 on 6/9/2011 at 12:25 p.m., she indicated that if the resident was up all night because she was not tired, then she would be more sleepy during the next day and was difficult to arouse. Review of the 10/22/2010 to 5/9/2011 monthly psychiatrist visits indicated the following: "Staff report had had no mood or behavior issues. No episodes of agitation, anxiety or yelling out. No problem with sleep or appetite. No apparent adverse reaction from current psychiatric		addressed in regards to residents receiving psychotropic medications. On 6/27/2011the Director of Nursing spoke with the consulting pharmacist to discuss expectations of completing required GDR's on psychotropic medications. Pharmacist understands and agrees to make recommendations for GDR's as indicated. Staff was in-serviced on 6/29/2011 on the importance of providing supportive documentation for psychotropic medication changes and indications for use. Social Services will review recommendations, and supporting documentation for GDR's, behaviors and medication changes during the Psychotropic Medication Review/ Behavioral meeting.The DON, SSD or designee(s) will audit new orders received for GDRs weekly x 4 weeks, and then monthly to ensure orders have been processed and that care plans have been updated as indicated. Results from the audits will be reviewed monthly at the PI committee meeting for a minimum of up to 1 year to ensure 100% compliance. After 1 year, if 100% compliance has not been achieved, the QA observations will continue to be conducted monthly and reviewed at the monthly PI committee meeting until 100% compliance has been achieved. Systems will be updated as indicated.	

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	medications. Psychiatrist to see to manage psychiatric medications and psychiatric diagnosis." During the 5/9/2011 visit, the psychiatrist did indicate the staff informed him the resident was sluggish today and may benefit from reduction in meds. A new order was received to decrease the Ativan from 0.25 mg three times daily to twice daily. 2. Review of the clinical record for Resident #104 on 6/6/2011 at 9:45 a.m., indicated the resident had diagnoses which included, but were not limited to, advanced Alzheimer's and anxiety. Review of the April 2011 monthly physician orders signed by the physician on 4/13/2011 indicated the resident was receiving: - Ativan [for anxiety] 0.5 mg - give 1 tablet orally 2 times a day- ordered on 10/13/2010 - Ativan 0.5 mg - give 1/2 tablet orally at 5 P M - ordered on 2/24/2011. - Ambien (for sleep) 5 mg - give 1 tablet every night at bedtime - ordered on 10/13/2010. Review of the nursing notes between 12/3/2010 and 2/24/2011 and the Social Service notes between 11/12/2010 and 2/1/2011 failed to locate documentation as to why the 2/24/2011 dose of Ativan had been added. During an interview with Social Worker #1 on 6/8/2011 at 12:24 p.m., she indicated the resident has had no behaviors since being moved off the Alzheimer unit 1/19/2011 and did not know why the resident continued to remain on the medications without gradual dose reductions other than it was the family's request she be kept on			

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	them. During an interview with the DoN on 6/9/2011 at 8:40 a.m., he indicated it was the family who was making the decision to keep the resident on the psychiatric medications. Review of the nursing notes between 2/24/2010 and 5/4/2011 and the Social Services' notes through 4/1/2011 and the Behavior Intervention Monthly Flow records between January 2011 and June 2011 failed to locate documentation of the resident experiencing behavior problems to justify the resident not having gradual dose reductions. 3. Review of the clinical record for Resident #36 on 6/6/2011 at 11:38 a.m., indicated the resident had diagnoses which included, but were not limited to, dementia with depression and behavior disturbance, paranoid state, and depressive disorder. On 1/13/2011, the psychiatrist reduced the resident's Zyprexa (a psychotropic for behaviors) from 5 mg at bedtime to 2.5 mg as a gradual dose reduction. On 2/10/2011, staff informed the psychiatrist that the resident was making inappropriate sexual comments to female residents and the psychiatrist re-instated the medication back 5 mg and the resident had experienced a failed GDR. On 3/10/2011, the psychiatrist increased the resident's Depakote from 250 mg - 1 capsule in the morning to 125 mg - 1 capsule 3 times a day. Documentation was lacking in the nursing and social service notes as to the reasoning for the increase in the medications. During an interview with Social Worker #2 on			

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	6/9/2011 at 2:10 p.m., she indicated she had spoken to the resident sometime in February 2011 about one incident of inappropriate sexual behavior, but indicated she did not investigate as to whether the resident or someone else was the instigator and what actions were taken. Review of the Monthly Behavior Monitoring Flow Records and nursing and social service notes between October 2010 and June 2011 failed to locate documentation of the resident having any type of inappropriate behaviors. During an interview with Social Worker #1 on 6/8/2011 at 12:24 p.m., she indicated Resident #20 and #36 had a past history of behavior issues, but nothing current. On 6/9/2011 at 8:27 a.m., the DoN presented a copy of the facility's current policy on "Psychotropic Medication Administration Mental Health Referral Consultation". Review of this policy included, but was not limited to, "...5. All residents currently receiving any psychotropic medications will be reviewed to insure that there is a diagnosis and documentation to clinically support the appropriate use of the medication...12. Any resident on psychotropic medications will be reviewed in weekly interdisciplinary meetings..." The DoN also presented at the same time, a copy of the facility's current policy on "Psychotropic Drug Reduction Program". Review of this policy included, but was not limited to, "Objective: To evaluate the use of psychotropic drugs (chemical restraints) in the facility in an effort to consistently ensure their appropriate utilization, thus reducing and preventing the use of psychotropic drugs (chemical restraints) whenever possible...Policy: All residents who are currently on any			

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	psychotropic medication will be evaluated to determine the necessity of the drug...Goals: ...1. That the lowest possible dose be used with every psychotropic drug administration and that each psychotropic drug is appropriate for each resident's medical condition..." During an interview with Social Worker #1 on 6/9/2011 at 1:15 p.m., she indicated that the meetings were not held weekly, but monthly and the only residents reviewed at these meetings would be anyone with a change in medications, not everyone. 3.1-48(a)(3) 3.1-48(a)(4)			
F0411 SS=D	The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist. Based on record review and interview, the facility failed to follow-up on a dental recommendation for 1 of 1 resident reviewed for dental issues in a sample of 24 residents. (Resident #44) Finding includes:	F0411	The professional cleaning dental recommendation for Resident #44 has been reviewed. The Resident's responsible party/daughter has provided written documentation that she was and is aware of this recommendation.	07/10/2011

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	The clinical record for Resident #44 was reviewed on 6/7/11 at 3:25 p.m. A consult dentist note dated 08/20/10 included, but was not limited to, "Nothing hurting or bothering patient at this time. Eating just fine. Patient has several teeth that are present. Dr. [named] highly recommends a professional cleaning at our office. A letter was sent to patient's resp. (responsible) party to see if this can be arranged." A hand written note on the form indicated "9/27/10 [named daughter] will take her after Oct. 15th. Dtr (Daughter) to make appt. (appointment)." In interview with Social Worker #2 on 6/9/11 at 2:10 p.m., she indicated it was her responsibility to follow-up with the daughter to ensure the dental appointment was made which had not been done. Documentation was lacking in the Social Service notes of any follow-up since 9/27/10. 3.1-24(a)(1) 3.1-24(a)(3) 3.1-24(b)		Resident attended an appointment at Dr. Hartman's Office on 6/30/11 at 11 am. Transportation was provided by Mission Transportation. Residents receiving contracted in-house dental services have the potential to be affected. An audit of residents currently residing in the facility that receive contracted dental services was completed on 6/28/2011. The audit reviewed any recommendations for additional outside dental consultations (i.e. oral surgeon referrals) during the past 90 days. The audit revealed there were no outside dental referrals that had not been followed-up on.Social Services staff and a representative from nursing will be assigned to round with the dental physician(s) during in-house consultations to ensure that any new orders or recommendations are received, documented and processed. Social Services staff were in-serviced on 6/24/11 by Lacy Beyl & Co. on case management to ensure medically related social services are provided. New orders related to dental referrals requiring additional outside referral services will be reviewed in the Monday-Friday department head meeting. The orders will then be taken to the Monday-Friday clinical meeting to ensure that the resident's care plan is updated as	

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			indicated. Don, SSD or designee will audit new telephone orders received dental consultations weekly x 4 weeks, and then monthly to ensure orders have been processed additional outside referrals have been obtained or scheduled, and that the care plans have been updated as indicated. Results from the audits will be reviewed monthly at the PI committee meeting for a minimum of 1 year to ensure 100% compliance. Systems will be updated as indicated. After 1 year, if 100% compliance has not been achieved, the PI observations will continue to be conducted and reviewed at the PI Committee meeting until 100% compliance has been achieved.	
F0428 SS=D	The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. Based on record review and interview, the facility failed to ensure the consultant pharmacist made recommendations for gradual dose reductions on psychotropic medications for 1 of 3 residents reviewed for gradual dose reductions in a sample of 24 residents (Resident #20); and failed to ensure there was sufficient documentation to justify the need for an increase in	F0428	Upon review of Resident # 20's medical record, documentation is present in Resident # 20's medical record from November 2010 thru April 2011 in the Psychiatrist's Follow-up Evaluation Sheet and the Pharmacists review sheet that validates compliance that the house psychiatrist and the Pharmacy consultant assessed the resident's need for a GDR	07/10/2011

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	anti-anxiety and psychotropic medications for 1 of 3 residents reviewed for gradual dose reductions in a sample of 24 residents. (Residents # 104) Findings include: 1. Review of the clinical record for Resident #20 on 6/8/2011 at 9:25 a.m., indicated the resident had diagnoses which included, but were not limited to, senile dementia with behavior disturbance, depressive disorder, and psychosis. The June 2011 monthly physician orders signed by the physician on 6/1/2011 indicated the resident was receiving the following psychotropic and anti-anxiety medications: - Buspar (for anxiety) 10 milligrams [mg] - give 2 tablets orally 3 times a day - ordered on 5/3/2010. - Depakote (for psychosis) 125 mg - give 2 capsules orally 2 times a day - ordered on 5/3/2010 - Depakote (for dementia with behavior disturbance) 125 mg - give 3 caps orally 2 times a day - ordered on 5/3/2010. - Neurontin (for anxiety state) 100 mg - give 1 capsule orally 3 times a day -		monthly. Additionally, there is no documentation found in the notes that the resident was experiencing any of the above noted changes that supports a change in the resident's treatment plan and that the current medication regimen was effective. On 5/9/2011, the resident was experienced some increased drowsiness which the Psychiatrist addressed at that time to include changes in the resident's medication regimen.Resident # 104's, P.O.A. is involved in this resident's care on a daily basis for several hours throughout the day and evening. She is aware and participates in the decision process for medication changes. In interview with the P.O.A., she verifies that she requested a GDR not be attempted. For residents # 20 and # 104 documentation has been added to the medical records supporting the changes/GDR's of the medications by nursing and social services. Residents receiving psychotropic medications have the potential to be affected by the alleged deficient practice.An audit of residents receiving a psychotropic medication within the last 90 days was completed to evaluate if the need of a GDR per the facilities policy. The audit revealed that the need of a GDR has been addressed in regards to residents receiving psychotropic medications. Attempts or	

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	ordered on 5/3/2010 - Neurontin (for anxiety state) 100 mg - give 2 caps orally at bedtime - ordered on 5/3/2010 - Lexapro (for depressive disorder) 10 mg - give 1 tablet orally once a day - ordered on 5/3/2010 - Lorazepam (for anxiety) 0.5 mg - give 1/2 tablet orally 2 times a day - ordered on 5/9/2011 (was 0.5 mg - 1/2 tablet 3 times a day) - Remeron (for depressive disorder) 15 mg - give 1 tablet orally at bedtime - ordered on 5/3/2010 - Risperadol (for psychosis) 2 mg - give 1 tablet orally every 12 hours - ordered on 5/3/2010 Review of the consultant pharmacist's monthly reports between 11/2010 and May 2011 failed to note any recommendations from the pharmacist for gradual dose reductions on the resident's medications. During an interview with the Director of Nursing [DoN] on 6/9/2011 at 9:10 a.m., he indicated that if the pharmacist marked "NI" [no irregularities], then no recommendations were made for gradual dose reductions.		completion of a GDR has been completed on residents in which a GDR was not contraindicated. This included a review of physician orders for residents receiving psychotropic medications has been completed. The audit revealed adequate indication for the use of these medications is documented in the resident's medical record. Staff was inserviced on 6/27/2011 on the importance of providing supportive documentation for psychotropic medication changes and indications for use. Staff was inserviced on 6/27/2011 on the importance of providing documentation of non-pharmacological interventions prior to administering a PRN (as needed) psychotropic medication and indications for use prior to changing hypnotics from PRN to routine. The facilities policy on completing behavior monitoring/interventions was also reviewed. Examples of appropriate documentation were provided. Social Services will review recommendations, and supporting documentation for GDR's, behaviors and medication changes during the Psychotropic Medication Review/ Behavioral meeting.The DON, SSD or designee(s) will audit new orders received for GDRs weekly x 4 weeks, and then monthly to ensure orders have been processed and that care plans	

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	Review of a 5/10/2011 care plan for the resident being at risk for side effects from antipsychotic drug use listed one of the approaches as being "Pharmacy consult review of medication monthly." During an interview with the DoN on 6/10/2011 at 10:50 a.m., he indicated that he had spoken with the consultant pharmacist who indicated to him that the reason she had not made any recommendations for gradual dose reductions was because the psychiatrist was writing "A trial dose reduction of the psychiatric medications listed above,...are contraindicated secondary to risk for exacerbation of: anxiety, mood dysregulation, behavioral disturbance." Documentation was lacking in the nursing notes, social service notes and behavior monitoring flow records between 10/2010 and June 2011 of the resident having experienced any type of behavioral issues. On 6/10/2011 at 11:20 a.m., the DoN presented a copy of the May 17, 2011 Gradual Dose Reduction Tracking Report for Resident #20 indicated no dose reductions have been attempted since implementation of the medications on 5/8/2010 and that none were being planned.		have been updated as indicated. Results from the audits will be reviewed monthly at the PI committee meeting for a minimum of up to 1 year to ensure 100% compliance. After 1 year, if 100% compliance has not been achieved, the QA observations will continue to be conducted monthly and reviewed at the monthly PI committee meeting until 100% compliance has been achieved. Systems will be updated as indicated.	

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	2. Review of the clinical record for Resident #104 on 6/6/2011 at 9:45 a.m., indicated the resident had diagnoses which included, but were not limited to, advanced Alzheimer's and anxiety. Review of the April 2011 monthly physician orders signed by the physician on 4/13/2011 indicated the resident was receiving Ativan [for anxiety] 0.5 mg - give 1 tablet orally 2 times a day- ordered on 10/13/2010 and Ativan 0.5 mg - given 1/2 tablet orally at 5 P M - ordered on 2/24/2011. Review of the nursing notes between 12/3/2010 and 2/24/2011 and the Social Service notes between 11/12/2010 and 2/1/2011 failed to locate documentation as to why the 2/24/2011 dose of Ativan had been added. Documentation by the consultant pharmacist was also lacking requesting the facility provide reasoning as to why the new dosage was necessary. Review of a 6/5/2008 care plan for the resident being at risk for adverse effects related to taking anti-anxiety and hypnotic medications, with a review date of 5/2/2011, listed as one of the approaches "Pharmacy consultant to review and make GDR [gradual dose reductions]			

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	155070	A. BUILDING 00 B. WING	06/10/2011

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	recommendations as indicated." On 6/9/2011 at 8:27 a.m., the DoN presented a copy of the facility's current policy on "Psychotropic Medication Administration Mental Health Referral Consultation". Review of this policy included, but was not limited to, "...5. All residents currently receiving any psychotropic medications will be reviewed to insure that there is a diagnosis and documentation to clinically support the appropriate use of the medication...8. Pharmacy consultants will review the drug regimen for each resident monthly, making recommendations as necessary...." 3.1-25(j)			

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F0441 SS=D	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, record review and interview, the facility failed to ensure infection control procedures/policies for hand washing were followed for 1 of 2 nurses observed during 1 of 2 resident	F0441	No harm has occurred to Resident # 12 in regards to the alleged deficient practice. LPN # 1 re-educated on 6/30/2011 on proper hand-washing technique when performing dressing	07/10/2011

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	dressing changes in the sample of 24. (LPN #1, Resident #12) Findings include: On 6/8/11 between 1020 a.m. and 11 a.m., LPN #1 was observed gathering supplies to do a dressing change for Resident #12. With the resident permission LPN#1 washed his hands and donned gloves. As the resident was turned to his left side, the Certified Nursing Assistant (CNA) who was assisting noted stool in the brief. LPN #1 went to the opposite side of the bed to hold the resident over with his gloved hands placed on the residents left hip and thigh. After the resident was cleansed, the CNA and LPN #1 switched sides. Without changing his gloves, LPN #1 poured the normal saline onto the gauze and proceeded to cleanse the area over the coccyx in a circular motion. He then changed gloves. On 6/9/11 at 8:30 a.m., the Director of Nursing provided a copy of the Wound Care Procedure for Major Wounds, revised 5/21/2004, which included, but was not limited to: 6. Explain the procedure to the resident. 8. Put gloves on. 13. Put on clean gloves prior to cleaning the wound. LPN #1 failed to don clean gloves prior to cleansing the wound. In interview with		changes to include guidelines for the donning and removal of gloves. Residents receiving dressing changes have the potential to be affected by the alleged deficient practice. Licensed nursing staff were educated on 6/29/2011on proper hand-washing technique when performing dressing changes to include guidelines for the donning and removal of gloves. Newly hired licensed nursing staff will be trained on our policy and procedure for dressing changes with emphasis on hand-washing and guidelines for the donning and removal of gloves. In, addition licensed nursing associates will receive re-education on this policy and procedure when completing annual skill competencies. SDC or designee will complete hand washing/gloves skills competency on 2 nurses from each unit weekly x 4 weeks and then monthly. Results from the QA observations and/ or audits will be reviewed monthly at the PI committee meeting for a minimum of 1 year to ensure 100% compliance. After 1 year, if 100% compliance has not been achieved, the QA observations will continue to be conducted monthly and reviewed at the monthly PI committee meeting until 100% compliance has been achieved. Systems will be updated as indicated.	

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	the Director of Nursing, at this time, he indicated the nurse should have changed gloves prior to cleansing the wound. 3.1-18(b)(1)			
F0508 SS=D	The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. Based on record review and interview, the facility failed to obtain an ordered chest X-ray for 1 of 2 residents reviewed with a chest X-ray order in a sample of 24. (Resident #121) Findings include: The clinical record for resident #121 was reviewed on 6/8/11 at 11:15 a.m. The resident's diagnoses included, but were not limited to Alzheimer and stroke. Nurse's Notes included, but were not limited to "3/14/11 0950 Resident found restless, lung crackles bilaterally, O2 (oxygen) 79 % (normal 90 -100), turning purple, color on assessment. Oral and nasal suctioning initiated. O2 of 6L (liters) /nc (nasal cannula) administered - per Dr. [named] order. O2 98 % post administering. CBC (complete blood count), BNP (Basic Panel), chest x-ray recommended by DON. Dr. [named] Ok's	F0508	Resident # 121 no longer resides in the facility.An audit of x-ray orders dating back 90 days was completed on 6/28/2011of the 100 unit to assess for any missed x-ray orders. Orders had been transcribed and obtained per physician orders. Licensed nursing staff was in-serviced on ensuring the transcription and follow-through of X-ray orders.X-ray orders will be reviewed in the Monday thru Friday daily department head meeting as well as the daily clinical meeting to ensure adequate follow-up of the orders. The DON or designee will audit new X-ray orders 5x/ week x 4 weeks, weekly x 3 months, then monthly to ensure the orders have been transcribed and processed appropriately.Results from the QA observations will be reviewed monthly at the PI committee meeting for a minimum of 1 year to ensure 100% compliance. After 1 year, if 100% compliance has not been	07/10/2011

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	it. Resident stable after a while." On 3/14/11 at 0950 ((950 a.m.) a Telephone Order was obtained which included, but was not limited to "chest x-ray on 3/15/11." Documentation was lacking the chest x-ray was completed. On 3/17/11 at 4 A a Telephone Order was obtained which indicated "Chest x-ray to R/O (rule out) pneumonia and Hyperventilation P.E. (pulmonary embolus) per Dr. [named]." On 6/9/11 at 12:30 p.m., in interview with the Director of Nursing, he indicated he could not find where the X-ray had been ordered. 3.1-49(g)		achieved, the QA observations will continue to be conducted monthly and reviewed at the monthly PI committee meeting until 100% compliance has been achieved. Systems will be updated as indicated.	
F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.			

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	Based on record review and interview, the facility failed to ensure the clinical records were complete and accurately documented for 2 of 3 residents with PASARR Level II [Pre-Admission Screening and Annual Resident Review] recommendations for mentally retarded individuals in a sample of 24. (Resident #59, #48) Finding includes: 1. The clinical record for Resident #59 was reviewed on 6/7/11 at 1:25 p.m. The resident's diagnoses included, but were not limited to mental retardation and cerebral palsy. Review of the PASARR dated 04/08/10 indicated "Has a developmental disability and a mental illness; Requires resident review in one year." The PASARR assists in determining the resident's current programming and service needs. Documentation was lacking in the clinical record for a PASARR dated 2011. 2. The clinical record for Resident #48 was reviewed on 6/8/11 at 1 p.m.. The resident's diagnoses included, but were not limited to mental retardation and epilepsy. Review of the PASARR dated 3/19/2010 indicated" requires resident review in one year." Documentation was lacking in the record of a yearly PASARR for 2011. On 6/7/11 at 1:45 p.m., in interview with Social Worker #1, she indicated the Level II for Resident #59 and #48 had not been done. She would call the Agency and check on the status. On 6/7/11 at 15:35 (3:35 p.m.), she provided a	F0514	The 2011 PASARR Annual Resident Review was obtained and reviewed for Residents #48 and #59. All Residents with an MR/DD diagnosis have the potential to be affected. There are currently four Residents with this diagnosis. The Level II paperwork was reviewed for all four. Only Resident #48 and #59 are requiring annual reviews. On 6/24/11, Social Services Staff were in-serviced on PASARR Level II reviews by a QMRP with Lacy Beyl and Company. The MR/DD and Level II list was updated to include annual reviews. Social Services staff will notify Bureau of Developmental Disability Services 60 days prior to required annual review, 30 days prior to required annual review and weekly therafter until the paperwork is received. Documentation of communication will occur on a telephone log and in the social services notes in the medical record. HIM or designee will conduct a quarterly audit to ensure that the required Level II paperwork is on the chart. Audits will be reviewed in the PI committee meeting for a minimum of 1 year to ensure 100% compliance. After 1 year, if 100% compliance has not been achieved, the audits will continue to be conducted and reviewed at the monthly PI committee meeting until 100% has been achieved. Systems will be updated as indicated.	07/10/2011

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	copies of the Level II faxed to the facility, at this time. The Level II for Resident #59 was completed on 3/18/2011 and the Level II for Resident #48 was completed on 4/8/2010. . The Social Worker failed to obtain the PASARR so as to complete the medical record and review it for any possible changes to the resident service needs and programming. On 6/7/11 at 1:45 p.m. in interview with Social Worker #1, she indicated the resident review was due in April 2011 and had not been completed. At 15:35 (3:35 p.m.) she provided a copy of the Level II faxed to the facility for Resident #59 and #48. She indicated, at this time, she had contacted the wrong department. 3.1-50(a)(1) 3.1-50(a)(2) 3.1-50(a)(2)			
F0516 SS=D	A facility may not release information that is resident-identifiable to the public. The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. The facility must safeguard clinical record information against loss, destruction, or unauthorized use. Based on record review and interview, the facility failed to safeguard clinical record information and ensure the resident dialysis book was safeguarded for 1 of 2 dialysis residents reviewed in a sample of	F0516	Residents who receive dialysis services have the potential to be affected by the alleged deficiency. An audit was completed on 6/28/2011 to ensure that no other residents were affected by the	07/10/2011

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	24. (Resident #109) Findings include: The clinical record for Resident #109 was reviewed on 6/8/11 at 1 p.m. The resident's diagnoses included, but were not limited to, chronic kidney disease with dialysis. At the time of review, the facility could not locate the blue dialysis book. On 6/9/11 at 2:30 p.m., the Director of Nursing indicated the blue dialysis book was not at the dialysis center and the EMS (Emergency Medical Service) indicated the binder was left in the ambulance on the stretcher. On 6/10/11 at 9 a.m., the Assistant Director of Nursing provided the dialysis information which was faxed on 6/9/11 at 4:22 p.m. from the [named] dialysis center. The information was for treatment received from May 26, 2011 thru June 9, 2011. Signed Physician Orders dated 6/11 indicated the resident was receiving dialysis three times a week since 1/30/11. In interview with the Director of Nursing on 6/11/11 at 11:35 a.m., he indicated the information from the dialysis center was sent yesterday evening at the facility request. He wanted the last two weeks, as the dialysis center nor the EMS could find the resident's blue binder. He wanted to		alleged deficient practice, and none were found to be out of compliance. New facility protocol will be for the Dialysis Centers to begin faxing the facility a report after each visit to ensure communication between facility and center occurs. DON spoke with the DON at FMC Dialysis center on 6/28/2011 and to Regional Coordinator with Davita Dialysis on 6/29/2011 to notify them of new facility protocol and they agreed to assist and comply with request. Don or Designee will complete weekly audits X 4 weeks and then monthly to ensure Dialysis Center communication sheets are received and filed appropriately. Results from the audits will be reviewed monthly at the PI Committee Meeting for a minimum of one year to ensure 100% compliance. System will be updated as indicated. After 1 year if 100% compliance has not been achieved, the PI observations will continue to be conducted monthly and reviewed until 100% compliance has been achieved.	

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	recreate the binder. Hours have been spent trying to locate the book. On 6/10/11 at 10:20 a.m., the Administrator provided the contract titled "Nursing Home Dialysis Transfer Agreement" dated April 24th, 2009 which included, but was not limited to, "Now, therefore, the Owner and Company agree as follows: 2. center Obligations d. In providing dialysis treatments to Designated Residents, Center shall adhere to the requirements of applicable state and federal law and regulations, and shall maintain Policies and Procedures that provide for quality patient care, infection control, emergency care, proper waste handling, maintenance of equipment, water treatment, patient record keeping, and patient safety." On 6/10/11 at 12:35 p.m., the Administrator provided the policy and procedure for "Notice of Privacy Practices" dated 12/29/08, which included, but was not limited to "Your Health Information Rights Our Responsibilities. The Facility is required to: maintain the privacy of your health information." On 6/10/11 at 1:45 p.m., the Administrator provided a copy of the Agreement for ambulance Services dated			

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	January 26, 2011 which included, but was not limited to "2. Duties and Obligations of Provider g. confidentiality of Resident Information. Provider shall maintain confidentiality of all resident information in accordance with any and all applicable federal, state, or other confidentiality laws, regulations, rules, or guidelines, including HIPAA (Health Insurance Portability and Accountability Act of 1996) requirements and the prevailing confidentiality rules as established by the Facility. In accordance with the privacy Rule, Provider shall take reasonable steps to ensure that all actions of its employees, Business associates (as this term is defined in the privacy Rule) and all other persons over whom it has control comply with Provider's obligations under the Privacy Rule. Provider shall execute a HIPAA Business Associate Agreement with any of Provider's Business Associates prior to disclosing any protected health information in connection with Services to be provided to Facility...3. Duties and Obligations of Facility. b. Record Maintenance. Facility shall (i) have primary responsibility for maintaining all resident records, and (ii)make available to Provider for review and inspection the individual resident treatment records necessary for the proper evaluation, screening and treatment of Facility's			

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	residents as appropriate to Provider's provision of Services." On 6/10/11 at 1:45 p.m., the Administrator indicated neither the dialysis center nor the ambulance service could find the blue binder containing confidential information related to Resident #109 and his treatment at the dialysis center, which was a communications binder between the facility and the center. 3.1-50(d)			
F9999	State Rule Finding 3.1-4 NOTICE OF RIGHTS AND SERVICES If the facility is required to submit an Alzheimer's and dementia special care unit disclosure form under IC 12-10-5.5, provide the resident at the time of admission to the facility with a copy of the completed Alzheimer's and dementia special care unit disclosure form. This state rule was not met as evidenced by: Based on interview and record review, the	F9999	A copy of the Alzheimer's/Dementia Special Care Unit Disclosure Form was mailed to Residents residing on that unit on 6/7/11. Residents admitted to the Alzheimer's/Dementia Special Care Unit are subject to the alleged deficient practice. A copy of the Special Care Unit Disclosure Form will be placed in the Facility Admission Binder and given to new admissions to this unit. Resident or Responsible Party will be asked to sign that they have received a copy of the Disclosure Form. An audit will be conducted monthly by the HIMD Director to ensure a copy of the Alzheimer's/Dementia Special Care Unit Disclosure Form was	07/10/2011

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	facility failed to provide 3 of 6 residents residing on the Garden Terrace Specialized Dementia & Alzheimer's Care Unit in a sample of 24 a copy of the Alzheimer's and Dementia Special Care Unit disclosure form. (Residents #68, 88, 17) Findings include: 1. The clinical record for Resident #68 was reviewed on 6/7/11 at 1100 a.m. The resident was admitted to the facility on 1/17/2011 to the Alzheimer's unit with a diagnosis of Alzheimer and dementia. Documentation was lacking the resident/family received a copy of the completed Alzheimer's and dementia special care unit disclosure form. 2. The clinical record for Resident #88 was reviewed on 6/8/11 at 10:55 a.m. the resident was admitted to the facility on 4/18/2011 to the Alzheimer's and dementia special care unit with a diagnosis of dementia with behaviors. Documentation was lacking the resident/family received a copy of the completed Alzheimer's and dementia special care unit disclosure form. 3. The clinical record for Resident #17 was reviewed on 6/8/11 at 8:05 a.m. The resident was admitted to the facility on		given to new admissions. Results from the audit will be reviewed at the monthly PI Committee Meeting for a minimum of 1 year to ensure 100% compliance. If 100% compliance has not been achieved, the audits will continue to be conducted monthly PI Committee meeting until 100% compliance has been achieved. Systems will be updated as indicated.	

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	5/25/2011 to the Alzheimer's unit with a diagnosis of Alzheimer's disease. Documentation was lacking the resident/family received a copy of the completed Alzheimer's and dementia special care unit disclosure form. In interview with the Administrator on 6/7/11 at 3:45 p.m., she indicated residents who were admitted to the Special Care Unit had not received a copy of the disclosure form. In interview with Social Worker #2 at this time, she indicated she does not provide the form to the resident/families and was not aware they were to receive the form. On 6/10/11 at 9:55 a.m., the Administrator provided a list of 28 current residents, three of whom were in the sample of 24, admitted to the Garden Terrace Dementia Care Unit from 9/1/2010 through 6/9/2011. 3.1-4(b)(11)			